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ABSTRACT

This document contains chapter 6 (5 articles) of a collection of 35 articles primarily from American Association for Counseling and Development (AACD) publications on the most important legal and ethical topics about which all school counselors need to be informed. "Ethical Issues Involved With the Use of Computer-Assisted Counseling, Testing, and Guidance Systems" (James P. Sampson, Jr. and K Richard Pyle) explores ethical issues and trends in computerized guidance and counseling services and testing. "The Counselor's Use of Microcomputers: Problems and Ethical Issues" (John H. Childers, Jr.) suggests that the use of microcomputers in the counseling office demands certain ethical precautions. "Ethical Issues in Counseling Gender, Race, and Culturally Distinct Groups" (Susan E. Cayleff) explores some of the ethical issues that counselors face when they work with populations different from their own. "Counseling Research: Ethics and Issues" (Sharon E. Robinson and Douglas R. Gross) summarizes the ethical issues involved in research. "Boundaries of Sex and Intimacy Between Client and Counselor" (Eli Coleman and Susan Schaefer) offer suggestions for counselors who are faced with sex and intimacy boundary issues in their professional counseling roles. (NB)

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SPECIAL ISSUES

Computers and computer products are increasingly present in school counseling offices. School counselors have made attempts to understand and utilize this modern technology, but many counselors are still unaware of the ethical issues involved in the use of computers. Sampson and Pyle (1983) explore ethical issues and trends in computerized guidance and counseling services and testing. Childers (1985) suggests that the use of microcomputers in the counseling office demands certain ethical precautions. Authors of both articles call upon the profession to develop ethical standards regarding computer use, and all three stress the importance of direct counselor-client contact in conjunction with the use of computers.

School counselors have a responsibility to provide services for all students, including those from other cultures. The counseling profession is a Western culture phenomenon; however, school counselors constantly interact with families and children who speak languages other than English, adhere to values different from those of the counselor, and conform to social expectations that may seem odd to the American school environment. The majority of practicing school counselors have not had the opportunity to take courses in multicultural counseling that are becoming more prevalent in modern counselor education programs. Cayleff (1986) explores some of the ethical issues that counselors face when they work with populations different from their own.

There is an increasing demand for school counselors to engage in field-based research. Documenting program effectiveness can do more to promote school counseling than all public relations

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efforts combined. But even if school counselors never conduct research themselves, they need to know the rights of students involved in research projects and the responsibilities of researchers. Robinson and Gross (1986) summarize the ethical issues involved in research.

Sexual intimacy with clients is perhaps the most pressing ethical problem in the counseling profession. School counselors are involved less often in sexual relationships with clients than are their colleagues who counsel adults. Nevertheless, clients, no matter what their age, often introduce sexual dimensions into the counseling relationship. Coleman and Schaefer (1986) offer suggestions for counselors who are faced with sex and intimacy boundary issues in their professional counseling roles.

Ethical Issues Involved With the Use of Computer-Assisted Counseling, Testing, and Guidance Systems

James P. Sampson, Jr. and *K Richard Pyle*

This article discusses (a) the growing use of computers in counseling, testing, and guidance; (b) potential ethical problems; and (c) principles for ethical use of computer applications.

An 18-year-old freshman experiencing frustration with her courses and having difficulty making the adjustment from high school to college, walks in the counseling and career planning center. There she sees a sign that tells students how they can take a battery of tests at a computer terminal. She sits down and proceeds to take a personality test on-line. After completing the test the results are interpreted via videotape. The student walks away with a printout of the test results.

A student assistant in the computer center is working late into the night regarding a task provided him by his supervisor. He accidentally accesses a file that provides him with test and personal information on a number of students whom he knows personally.

A senior comes into the career planning center to gain assistance with a career choice. He goes through a computer-assisted guidance program and makes a number of decisions regarding his career direction on the basis of the information provided him. A year later he discovers that much of the information that he used in making his decision was out of date and inaccurate.

A doctoral student, anxious to have data that will allow him to overcome the dissertation hurdle, accesses the data bank of a computer program that has stored student values profiles. He proceeds to get printouts on their profiles which he is to make use of in his research. This is done without checking with the students concerning their willingness to participate in such a research endeavor.

Trends That Have Impact on the Use of Computers in Counseling, Testing, and Guidance

One of the most significant developments of the past decade has been the impact of information technology on our daily lives. Beginning in science and business, information technology has become an important component of education, communications, and recreation. At the center of this revolution we find the computer. Two facts principally account for the increased use of the computer. First, there has been a steady reduction in the unit cost of computing (Dertouzos & Moses, 1979). Recent dramatic cost reductions in small electronic calculators and digital watches is a prime example. Second, the overall computing power of individual computers has increased (Atkinson, 1978). For example, the average large (mainframe) computer today is approximately 10 times faster in operation and stores 30 times more information in main memory than the average mainframe computer of 10 years ago. In essence, computers have become less expensive while at the same time becoming more powerful.

Two other trends are influencing the expanding use of computers. First, small, inexpensive, and easily maintained microcomputers (sometimes referred to as personal computers) are becoming a common feature in many businesses, homes, and schools. These microcomputers are used for either general computing, which involves many applications, or are used for special applications involving a few limited functions (e.g., accounting, analysis of laboratory specimens, or games). Microcomputers are designed for use by persons with little or no background or expertise in computer programming. The ease of technical operation and the wide variety of existing programs to operate various applications places the power of the computer in the hands of the general public. As average persons become proficient in programming, their ability to utilize the capabilities of their computer increases as well.

The second trend involves the use of computer networks. Improvements in communication technology have resulted in the connection of computers in various locations by telephone lines or by satellite. Using a communication device called an acoustic coupler modem it is possible, with proper permission, to access through a computer network a specific data file or program in a computer that is hundreds of thousands of miles away. As a result the data, programs, and computing power available to the individual has increased significantly over what is available on any one computer.

The net effect of the above developments is that computers are being used in applications that before now were the domain of person-to-person interaction. The use of automated 24-hour bank tellers is a prime example. Computer applications in counseling, testing, and guidance is another example. Functions of problem-solving, test administration, scoring and interpretation, information dissemination, and instruction in decision-making strategies are being carried out by an individual interacting with a computer.

Use of Computer Applications in Counseling, Testing, and Guidance

The advent of computer use in counseling, testing, and guidance came about as a result of the realization that there were aspects of the helping process that could be more effectively handled by a computer than by a counselor. These aspects are generally repetitive and are not viewed by many counselors as the most challenging or satisfying part of their work. Aspects of the helping process that are repetitive, as in information dissemination, or that follow a uniform sequence of steps, as in decision making instruction or administration of assessment instruments, are more effectively handled by a computer. Aspects of the helping process that involve exploring the nature of client concerns, facilitating an understanding of the factors involved, and identifying and following up on various action-oriented strategies are more effectively handled by a counselor. By using the computer for repetitive tasks, counselors are free to spend more time completing tasks that are well suited to their expertise, while avoiding tasks that are more efficiently completed by a computer. A secondary benefit of this approach is that after using the computer the client and the counselor share a common vocabulary and frame of reference for dealing with various concerns.

The widest computer applications in the helping professions have historically occurred in career counseling and guidance. At present, 25 computer-assisted guidance systems are available (Shatkin, 1980). These systems are available to a wide range of individuals in various age groups through public schools, colleges, libraries, public employment offices, and private agencies. The goal of these systems is to facilitate rational career decision making on the part of the individual. Katz and Shatkin (1980) categorize computer-

assisted career guidance systems as providing either career information or a combination of career information and guidance functions. The guidance functions in the latter type of system include assessment of values, skills, and interests as well as instruction in decision making. These systems tend to require more time to complete and model the complete decision making process as opposed to systems emphasizing only career information.

Computer-assisted testing and assessment have traditionally involved computer scoring of interest, ability, and values instruments at a remote location. With the advent of microcomputers, programs have been written that allow for administration, scoring, and generalized interpretation of test results in one session at the computer. There are several advantages to this approach. First, microcomputer-controlled equipment is available that allows persons with various visual, auditory, and physical disabilities to take tests with minimal staff assistance. This reduces the chance that a staff member might influence an individual's results. Second, a generalized interpretation of test results on microcomputer-controlled videotape can better prepare the client for discussing specific results with a counselor. Generalized interpretations introduce terminology, stress basic concepts, and provide some indication of test results in broad terms. This approach may not be appropriate for some instruments. Third, the traditional time lag and clerical work in scoring tests is eliminated. Fourth, potential scoring errors are significantly reduced.

Computer-assisted academic counseling is designed to assist individuals in enhancing their motivation and study skills as well as assisting individuals in eliminating behaviors that limit academic performance (e.g., test anxiety and procrastination). The Computer-Assisted Study Skills Instruction system (CASSI) (Sampson, 1980) is an example of one such approach. After it is determined that CASSI is an appropriate resource, individuals complete various assigned lessons and are then provided with assistance in implementing the concepts into their academic work. It is recommended that a counselor or a learning skills instructor assist individuals who are using this system.

Computer-assisted personal counseling is generally designed to assist individuals in solving personal problems. These systems are used as part of the counseling process with a counselor or are used without counselor intervention as an independent client-controlled resource. The specific purpose and design of existing systems vary considerably according to the therapeutic orientation of

the developer. The systems developed by Weizenbaum (1965, 1976) were based on a client-centered approach while the systems developed by Colby, Watt, and Gilberg (1966) and Taylor (1970) were based on a psychoanalytic approach. These systems were designed more for demonstration purposes than for providing a complete computer-assisted counseling system. Greist (1973) developed a system that evaluated an individual's clinical state and their potential for attempting suicide. The most comprehensive computer-assisted personal counseling system was developed by Wagman and Kerber (1978). PLATO DCS operates from a theoretical framework that is cognitive in nature and models the logic pattern of the computer. The system is designed to assist in resolving personal dilemmas by having the client progress through the following five sequenced and interrelated processes:

> (a) formulating the original case problem as a psychological dilemma; (b) formulating the extraction route for each dilemma component; (c) formulating the creative inquiry for each extraction route; (d) generating solutions for each creative inquiry; and (e) ranking and evaluating solutions. (Wagman, 1980, p. 18)

Individuals are referred to PLATO DCS by a counselor or are self-referred to the system. Follow-up counseling is available if requested by the individual.

Future Trends

In general the impact of information technology through the use of computers will continue to grow. Reductions in the cost and improvements in the performance of computers is projected to continue throughout this decade. Microcomputers will become more common in education, business, and the home. Individuals will have increasingly wider access to data and computer programs available at other locations through the use of computer networks. Computer applications in counseling, testing, and guidance will also grow as computers (especially microcomputers) become more

affordable to institutions and agencies providing services and as more systems are developed to meet specific individual needs. It is also likely that public acceptance of using a computer to assist in solving career, academic, and personal problems will increase as computers become a more accepted part of daily life.

Ethical Issues

Computer applications have the potential to augment the efforts of counselors in ways that enhance the growth, decision making skills, and problem solving abilities of individuals. Research evidence cited by Harris (1974), Pyle and Stripling (1976), Sampson and Stripling (1979), Katz (1980), and Wagman and Kerber (1980) support this conclusion. Computer applications also have the potential to undermine the client-counselor relationship and influence clients in ways that limit growth, decision making skills, and problem solving abilities. The potential negative impact of computer applications occurs when these applications are used in a manner that violates sound ethical principles for the provision of counseling and guidance services. Ethical principles are generally stated in a professional code of ethics. McGowen and Schmidt (1962) state that an ethical code, among other things, provides standards of practice to guide professionals when possible conflict situations arise in their work and help to clarify the responsibilities of the counselor toward the client.

At the present the *Ethical Standards* (American Personnel and Guidance Association, 1981) and the *Ethical Principles of Psychologists* (American Psychological Association, 1981) do not specifically address the ethical issues relating to the growing use of computer applications in counseling, testing, and guidance. The only exception to the above statement involves Principle 8e of the *Ethical Principles of Psychologists* which includes automated interpretation services under Assessment Techniques. Since it appears that the availability, use, and acceptance of computer applications will continue to increase, it seems important to revise existing ethical standards to include guidelines for appropriate use of such systems. Specific topics that need examination in terms of ethical standards include: (a) confidentiality of client data maintained on a computer; (b) use of computer-assisted testing and assessment; and (c) the need for counselor intervention with clients using computer-assisted counseling, testing, and guidance systems.

Confidentiality of Client Data

Confidentiality is generally regarded as an essential element in the provision of counseling and guidance services. Several unique problems exist in maintaining the confidentiality of client data stored on a computer.

First, the advancements in computer technology described previously make it cost effective to keep large amounts of data on an individual (Gambrell & Sandfield, 1979; Lister, 1970). Large quantities of data may or may not be necessary for the provision of services. Also, as more data are available the potential for abuse grows as well.

Second, technological advances also make it cost effective to keep records for longer periods of time in comparison with existing paper records (Gambrell & Sandfield, 1979). Data can be maintained even though they are no longer of any value in providing services; for example, test results that are out of date or personal problems that no longer exist.

Third, as data are transferred from test report forms or paper record forms into a computer record file mistakes or omissions can be easily made. The resulting inaccurate or incomplete information can be damaging to the individual, especially in view of the perception held by the general public that computer data have a high degree of value and reliability (Lister, 1970).

Fourth, the increased availability of microcomputers as well as remote terminals connected with large computers increases the possibility of unauthorized access to confidential data. Super (1973, p. 303) states: "Non-computerized records have occasionally been abused. But computerized records lend themselves to larger scale abuse." This problem has led Denkowski and Denkowski (1982) to suggest that counselors "not provide sensitive client information for entry into electronic data storage systems" (p. 374).

Fifth, the existence of computer networks described previously makes it possible to access confidential information stored in a computerized data bank. Confidentiality can be compromised if the data can be identified with a particular individual (Ad Hoc Committee on Ethical Standards in Psychological Research, 1973).

Sixth, many computer-assisted counseling and guidance systems can collect research data while the individual is at the terminal. It is possible to collect the data without the individual's knowledge or permission, thus violating established ethical principles of research.

In view of these problems the following ethical principles are suggested:

1. Ensure that confidential data maintained on a computer are limited to information that is appropriate and necessary for the services being provided.
2. Ensure that confidential data maintained on a computer are destroyed after it is determined that the information is no longer of any value in providing services.
3. Ensure that confidential data maintained on a computer are accurate and complete.
4. Ensure that access to confidential data is restricted to appropriate professionals by using the best computer security methods available ("appropriate professionals" are described in existing ethical standards).
5. Ensure that it is not possible to identify, with any particular individual, confidential data maintained in a computerized data bank that is accessible through a computer network.
6. Ensure that research participation release forms are completed by any individual who has automatically collected individually identifiable data as a result of using a computer-assisted counseling, testing, or guidance system.

Use of Computer-Assisted Testing and Assessment

Testing and assessment is an important part of providing many counseling and guidance services. Computer applications in this area can be effective or lead to the following unique problems.

First, microcomputers can be programmed to score a wide variety of tests accurately. It is possible that occasional equipment failures or problems with the program that scores the test will invalidate the client's results. The error may or may not be readily apparent.

Second, generalized interpretations of test results presented by microcomputer-controlled videotape may or may not accurately reflect the meaning of the scales as developed by the test author. At best, confusion may result from viewing a videotape containing inaccurate information; at worst, erroneous conclusions may be reached.

In view of these problems the following ethical principles are suggested, in addition to the six mentioned earlier:

7. Ensure that computer-controlled test scoring equipment and programs function properly thereby providing individuals with accurate test results.
8. Ensure that generalized interpretations of test results presented by microcomputer-controlled audiovisual devices accurately reflect the intention of the test author.

Need for Counselor Intervention

Existing computer applications in counseling and guidance use a variety of formats for counselor intervention. In some systems the counselor is involved before, during, and after an individual uses a computer system. In other systems the counselor serves as a consultant on an as-needed basis with the computer application operated as a stand-alone service. Considerable variation exists between these two options. Counselor intervention is typically provided in individual and group counseling formats. In some settings counselor intervention functions are divided between professional and paraprofessional staff. Sampson and Stripling (1979) indicate that advantages exist for providing counselor intervention in a structured as opposed to a nonstructured manner. The structured approach includes a systematic introduction and follow-up of computer use. Research conducted with the counselor intervening and managing the computer-assisted guidance process has demonstrated significant change in career maturity (Pyle & Stripling, 1976). Devine (1975) found no changes in career maturity when the student worked only with the computer without counselor intervention or management.

Several unique problems result from inadequate counselor intervention with individuals who are using computer-assisted counseling, testing, and guidance systems.

First, some individuals who are experiencing substantial emotional problems initiate their contact with a service agency by asking for specific information such as communication skills, motivation, or career choice. Individuals experiencing a moderate to severe crisis are unable to [illegible] a computer application effectively. The individual who fails at using such a system may be too embarrassed or discouraged to seek additional counseling. A related assessment problem occurs when, owing to a lack of adequate initial evaluation, an individual who is experiencing substantial emotional problems draws inappropriate conclusions from a generalized test interpretation.

Second, problems can result when clients are not adequately introduced to the process involved in using a computer application. Anxiety concerning the use of a computer has a negative effect on an individual's performance (Rohner & Simonson, 1981; Schraml, 1981). This anxiety relates in part to concerns that an inordinate amount of skill or mathematical expertise is required for successful operation of the computer or that a simple error made while using the system will result in damage to the computer equipment or the program being used. This anxiety tends to intensify the existing anxiety clients often have about the problem that led them to seek help. A related problem concerns client misconceptions about the nature of computer applications (e.g., the computer will provide a quick solution to the problem). The recent dramatic achievements in computer technology have led some individuals to believe that computers can accomplish tasks that are in fact presently impossible. Another related problem involves clients who fail to understand the basic concepts or procedures involved in using a computer application. When an introduction to a computer application is not provided, excessive anxiety, misconceptions, or misunderstandings may severely limit an individual's ability to benefit from using the resource.

Third, problems can result when a follow-up of the client's use of a computer application is not provided. For example, potential misunderstandings and misconceptions may not be corrected. Also, potential inappropriate use of a computer application may not be identified. Finally, the client's subsequent needs may not be examined. The lack of an appropriate follow-up may limit the beneficial results of using a computer application.

Fourth, the information contained in a computer-assisted career counseling and guidance system is only as good as its source. Career information from some sources may be inaccurate or formerly accurate information may be out of date.

Fifth, a computer application may, after a period of successful operation, fail to operate properly due to problems with equipment or computer programs. As a result clients may become so anxious or frustrated by an inoperative computer application that they discontinue the entire counseling process.

In view of these problems the following ethical principles are suggested:

9. Ensure that a client's needs are assessed to determine if using a particular system is appropriate before using a computer-assisted counseling, testing, or guidance system.

10. Ensure that an introduction to using a computer-assisted counseling, testing, and guidance system is available to reduce possible anxiety concerning the system, misconceptions about the role of the computer, and misunderstandings about basic concepts or the operation of the system.
11. Ensure that a follow-up activity to using a computer-assisted counseling, testing, and guidance system is available to correct possible misconceptions, misunderstandings, or inappropriate use as well as assess subsequent needs of the client.
12. Ensure that the information contained in a computer-assisted career counseling and guidance system is accurate and up-to-date.
13. Ensure that the equipment and programs that operate a computer-assisted counseling, testing, and guidance system function properly.
14. Determining the need for counselor intervention depends on the likelihood that the client would experience difficulties that would in turn limit the effectiveness of the system or otherwise exacerbate the client's problem. It is the counselor's responsibility to decide whether the best approach to avoiding the above problem for a specific client population is direct intervention or indirect intervention through the use of work-books, self-help guides, or other exercises. In general, academic counseling systems and career guidance systems that primarily provide information can be used effectively with less direct counselor intervention than personal counseling, testing, and assessment systems or career guidance systems that provide assessment and guidance functions. In spite of the fact that some academic and career systems may need less direct counselor intervention, the individuals who use these systems can still benefit from direct intervention when counselors are available.

The ethical principles presented in this paper have implications for the training of counselors, psychologists and career development specialists. One way of increasing the likelihood that computer applications are used in an ethical and appropriate manner is to ensure that students in training have a knowledge of: (a) the rationale for using computer applications; (b) common operational procedures; (c) common counselor intervention strate-

gies; (d) strategies for implementing computer applications into existing services (including staff training); and (e) related ethical issues. Beyond the general competencies described above, the student in training has an obligation to be familiar with the specific theoretical basis, operational procedures, and counselor intervention strategies of any computer application used by a client. This obligation also extends to any professional who is providing computer-assisted services to clients.

The ethical problems resulting from the use of computer applications in the helping professions are complex. The increasing use of computer-assisted counseling, testing, and guidance systems necessitates a thorough examination of the issues involved. These systems can be effective or ineffective depending on the way in which they are used. It is the responsibility of the profession to develop ethical standards that encourage effective and responsible use of computers in providing counseling, testing, and guidance services.

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The Counselor's Use of Microcomputers: Problems and Ethical Issues

John H. Childers, Jr.

Review of current counseling literature reveals a dramatic increase in the use of microcomputers and other technological advances by counselors (Daniel & Weikel, 1983; Sampson & Pyle, 1983), a trend that is predicted to continue (Daniel & Weikel, 1983). Several factors have contributed to this trend.

First, microcomputers are common in many work settings because they are small, relatively inexpensive, easily maintained, and powerful. A second factor is the availability of "user friendly" software. Numerous software programs that are easy to use and relatively inexpensive are currently available for various uses: vocational guidance, study skills, testing and assessment, statistics, word processing, spelling, educational programs, scheduling, record keeping, individualized educational plans, and many other uses.

The evolution of the microcomputer and related software packages is leading to a second computer revolution (Leveson, 1980). Cornish (1981) and Hald (1981) suggested that by the 1990s the capabilities of the microcomputer are likely to increase at least a thousandfold. There is little doubt that its impact will greatly affect how we work, relate, and gain information as well as numerous other life-style areas (Cianni-Surridge, 1983). The question is no longer "Will counselors find useful strategies for computer technology?" but "Will counselors use this technology in a responsible, ethical manner?"

Microcomputer technology has the potential to augment as well as to undermine both the relationship between client and counselor and the client's growth, decision-making skills, and problem-solving abilities (Sampson & Pyle, 1983). Counselors need to

examine the possible problems and ethical issues of using microcomputer technology. Currently, the *Ethical Standards* of the American Personnel and Guidance Association (1981) and the "Ethical Principles of Psychologists" (American Psychological Association, 1981) do not specifically address ethical issues related to microcomputer technology. Because of the prediction that there will be an increased use of computers and other technological advances by counselors, it is important to consider revising existing ethical standards to include guidelines for appropriate use of such technology (Sampson & Pyle, 1983).

A first step toward establishing such standards may be to identify and discuss representative problems and ethical issues. In this article I identify and discuss 11 issues that may have ethical implications for counselors and the counseling profession.

Confidentiality

Confidentiality is perceived as essential in the delivery of effective guidance and counseling services. Several special problems arise regarding how to maintain confidentiality of client data stored on a computer.

First, data stored on a computer, unless restricted to appropriate personnel, can be obtained by anyone. This suggests the importance of computer security procedures as well as identification of those who have authorized access to confidential data.

Second, confidentiality can be compromised if the data can be linked with a particular individual. Confidential data maintained in a computer should not identify a particular individual.

Third, many software programs collect and store data while the individual is at the terminal. As a result, it is possible to gather information without the individual's knowledge or permission. This suggests the importance of guidelines regarding informed consent and release forms for individuals storing identifiable data.

Data Storage

The issue of data storage is closely related to confidentiality. Several areas require the development of guidelines to protect client welfare.

First, the computer has made it cost effective to store large amounts of data. These data may or may not be necessary for the effective delivery of guidance and counseling services. Guidelines should be established to ensure that the information stored is appropriate and necessary for the services to be delivered.

Second, the computer has made it possible to store data for a long period of time even though it may no longer be useful in providing services. Thus, consideration should be given to establishing guidelines regarding the length of time data will be stored as well as what types of information will be retained.

Software Issues

Inadequate software is cited throughout the literature as the single greatest impediment to the computer revolution (Benderson, 1983). Benderson (1983) suggested that 95% of the available software on the market is not worth having. Critics point out that much of the existing software is mainly drill-and-practice and tutorial routines full of spelling and typographical errors and bugs that prevent the programs from working properly under certain conditions. Several issues involving software may require specific guidelines.

First, counselors face the important issue of selecting high-quality software. The majority of magazines dealing with computers provide evaluations of software, but the evaluations vary in quality and reliability. There is a need, therefore, for independent educational organizations to evaluate software programs. The two most widely recognized programs for screening and reporting on the quality of educational software are the Northwest Regional Education Laboratory's MicroSIFT Clearinghouse and the Education Product Information Exchange (Benderson, 1983).

The validity and reliability of software programs are also significant considerations. Software programs need to be evaluated by their users as well as by programmers, instructional designers, content experts, and clients to determine whether they meet various educational or therapeutic objectives.

Finally, counselors need to be concerned about procedures for updating information in software programs once they are on the market. The dissemination of outdated information to individuals seeking input for decision making is a major ethical issue.

Counselor-Assisted Software Programs

Most software programs in the area of guidance and counseling are designed to be used in conjunction with a counselor rather than by clients independently; thus, they should not be perceived as "stand alone" programs. Counselor-assisted software programs were not designed to replace contact with a counselor; therefore, when they are used by clients independently, an issue of professional concern arises.

Client-Screening Procedures

Although research generally supports the effectiveness of computer-assisted instruction, counselors should seriously consider establishing client-screening procedures for microcomputer use. There are several specific issues related to client-screening procedures.

First, a certain degree of skill in microcomputer technology is required for clients to be able to use microcomputers. This is the issue of computer literacy. There is no agreement in the professional literature on the definition of computer literacy. With software becoming increasingly user-friendly, clients will not be required to have an intimate knowledge of the computer or programming. The issue for counselors is not only what is computer literacy, but what degree of skill is required to use specific software programs. Consideration must eventually be given to matching clients and software programs according to the consumer's degree of skill. Mismatching a client and software will probably increase the client's feelings of low self-esteem, anxiety, sense of failure, helplessness, and frustration.

Second, microcomputer technology may result in a "hypervigilant" decision-making style (Janis & Mann, 1977) in which a person makes an almost obsessive attempt to take in all data before making a decision. This decision-making style often causes high anxiety because the individual fears an important piece of information still remains to be gathered before making a decision. This style often results in information overload. The hypervigilant client is aware of the many possibilities that exist but is so emotionally or intellectually involved that key issues may be missed. This client could be described as overly stressed. Screening procedures should be designed to identify hypervigilant clients.

Screening procedures for highly anxious clients should also be considered. Such clients may need to reduce their level of anxiety before being introduced to the microcomputer. This type of technology may only increase the anxiety level of certain clients.

Finally, screening procedures should be developed to help determine which services are most appropriate for which clients. Clients in crisis situations may turn to this technology when direct contact with a counselor would be more appropriate.

Use by Affluent Versus Poor Clients

Microcomputers may only increase the division between the rich and the poor in this country. Affluent school districts can afford microcomputer literacy programs, whereas many low-income districts lack the resources to support such programs. High technology and its related benefits belong to the more affluent. This trend has societal implications. For example, if society becomes increasingly characterized by high-technology innovations, people more familiar with the technology will have greater opportunities for better jobs and better education and will exercise more personal freedom in decision making.

Sexism

Becker (1983) reported that relatively few girls elect to take computer classes in high school. He suggested that by the time students reach high school, computers have become linked with the male sex. This may exclude girls from many future jobs. One solution would be to introduce microcomputer technology to students during the elementary grades, thereby possibly eliminating any sex role bias. Counselors should ensure that both sexes have equal opportunities to use computer technology.

Computer Literacy with Poor Socialization Skills

Advocates of computer education suggest that to be properly prepared for the future, people will have to achieve computer literacy. Today many people are becoming computer literate, but some of them may spend so much time interacting with technology

that they do not develop effective socialization skills. Such individuals may be as inadequately prepared for living in a rapidly changing world as those lacking computer literacy. Counselors should consider guidelines that would help in the development of the whole person.

External Locus of Control

Locus of control is a personality variable involving an individual's general expectancies of reinforcement or gratification (Rotter, 1966). Individuals with an internal locus of control believe that reinforcements are contingent on their own behavior, capacities, or attributes. Individuals with an external locus of control believe that reinforcements are not under their personal control but are under the control of powerful others, luck, fate, or chance (Joe, 1971).

Clients with an external locus of control may be more likely than are clients with an internal locus of control to reach a decision because "the computer told me this is the correct choice." That is, externally oriented clients may perceive that the microcomputer has power that is not under their personal control.

Procedures that ensure that a client accepts personal responsibility for his or her own decisions should be considered. The counselor and client should examine the array of potential solutions and make a commitment to action based on an examination of the solutions and their possible consequences. The client then can decide which solution he or she is willing to assume responsibility for implementing. This would help develop a client's internal locus of control.

Left-Brain Thinking

The left hemisphere of the brain has been associated with logical, rational, and digital thinking (Springer & Deutsch, 1981); the right hemisphere involves intuitive, metaphorical, and analogical thinking (Springer & Deutsch, 1981). Computer technology and its related software programs, which consist mainly of drill-and-practice and tutorial routines, reinforce left-brain thinking. Right-hemisphere thinking receives little or no reinforcement; consequently, consumers of technology may come to value left-brain

thinking over right-brain thinking. The goal of counseling is development of the whole person. This goal suggests that, with increasing emphasis on left-brain thinking, counselors may need to develop strategies that enhance and validate right-brain thinking.

Counselor Preparation

Most counselors and counselor educators have not been trained to use computer technology. Often counselors know less about computer technology than do many of their clients. This raises several issues at both the preservice and inservice training levels.

First, computer literacy is rapidly becoming a criterion for employment. Currently there is no specific requirement in the professional training standards (Commission on Standards and Accreditation, Association for Counselor Education and Supervision, 1977) that require counselors in training to be computer literate before graduating. If graduates of counseling programs are to be competitive for employment in the future, consideration should be given to including computer literacy in the professional training standards.

Second, few new counselor positions are being announced in school districts; thus, most of the counselors who will be in the schools during the next decade are already there. Probably these counselors are not computer literate. This lack of computer literacy suggests the importance of inservice training in school districts. Many existing inservice programs are designed for the classroom teacher. Counselors share many of the same needs as this group, but they also have unique professional needs. Counselor education programs should consider implementing inservice programs to prepare counselors for using microcomputers in their work environment. Although it is not necessary for counselor educators to deliver these inservice programs, they should provide input concerning the hardware and software needs of counselors.

Third, counselor educators need to be computer literate. Those who are not will have less opportunity to influence computer technology and how that technology affects their professional field. Counselor educators may want to consider becoming computer literate as part of their continuing professional development plan.

Fourth, professional organizations should be responsive to membership needs. These professional organizations need to provide inservice computer literacy programs for counselors and counselor educators.

Conclusion

Many counselors and counselor educators are frightened by computer technology. The computer is often perceived as a substitute for the counselor. Wrenn (1973) suggested that if a counselor is only performing the functions of information retrieval and cognitive analysis, he or she should be worried because a computer can perform these functions better. He stated that computers cannot completely substitute for counselors, but they will enable counselors to capitalize on human qualities, such as sensitivity to verbal and nonverbal cues and responsiveness to group interactions.

The effective use of microcomputers by counselors will mean that less time will have to be devoted to information retrieval and cognitive analysis. Counselors will be able to focus on the unique needs of their clients. For this to happen, it will be necessary to change the perceptions of many counselors toward technology and to redesign many guidance and counseling programs.

The counseling profession is now on the periphery of computer technology, but the use of computer technology by counseling professionals will increase. This technology can be used effectively or ineffectively. It is the responsibility of professional counselors to examine problems and to develop ethical standards that encourage the responsible use of computer technology in the delivery of guidance and counseling services.

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Ethical Issues in Counseling Gender, Race, and Culturally Distinct Groups

Susan E. Cayleff

This article addresses the complex ethical and cultural issues that arise with counseling women, Blacks, ethnic minorities, poor people, lesbians, and gays. Common dilemmas arising from the social context of the counselor-client relationship, the need to respect client autonomy, and the imperative for ethical and quality health care are outlined and discussed, and management strategies are suggested.

> *Dilemma for Special Focus Section.* Maria Gonzalez is a 32-year-old, first-generation, Mexican-American woman. She is married (3 years), has two children, and has been diagnosed as having uterine cancer. She adamantly refuses a hysterectomy, arguing (through an interpreter) that her husband will leave her, or if he stays, it will be the end of their marital and sexual relations. Even after repeated conversations with residents and clinical faculty in obstetrics and gynecology, she is unpersuadable. These practitioners refer her to a counselor, hoping that the counseling relationship will result in Maria's informed consent for the procedure.

The counselor-client relationship operates as a microcosm of the larger American social structure. It reflects the beliefs, stratifications, tensions, and injustices that exist in American society. In addition to reflecting American beliefs, counselors validate theories that determine general perceptions of women, minorities, and poor people. Like the physician-patient relationship in the medical model, the counselor-client relationship is hierarchical and thus replicates the power dynamics evidenced in other nonpeer relationships. Because professional counseling personnel have only

nonspecific ethical guidelines by which to conduct their interactions with culturally nondominant populations (the *Ethical Standards* of the American Association for Counseling and Development [AACD, formerly American Personnel and Guidance Association, 1981]), counselors should be aware that their own place within the larger culture—their social status, sex, and race—will probably influence both what they perceive as problems and dilemmas and how they respond to them (Cayleff, 1984).

For example, women, minorities, and poor people have been (and at times continue to be) labeled "sick" or mentally ill when in fact they have only varied from "normal" patterns of behaving and feeling as defined by others who take White, male, middle-class beliefs as the normative measure or the rule of health and desirability (Ehrenreich & English, 1978; Kristeva, 1982; Raymond, 1982; Scully & Bart, 1973; Smith-Rosenberg & Rosenberg, 1973). Examples include the widely documented labeling of women's physiological illnesses as psychogenic (Lennane & Lennane, 1973) and the frequent diagnostic errors made when psychiatric disorders are labeled psychoses more readily in Black patients than in White patients (Carter, 1983).

In these instances, counselors perpetuate cultural definitions of health and illness that can be used to stipulate acceptable social roles for women and minorities (Schur, 1984; Smith-Rosenberg & Rosenberg, 1973). Further examples include the 19th-century "disease" of drapetomania—the "illness" of Blacks running away to the North, the circumscription of women's social role in 19th-century America on the ground that women were biologically "weak," and the still widely held stereotypes that surface when counseling persons in same-sex love relationships, including denial or exaggeration of the clients' sexual orientation (Jones, 1974; Messing, Schoenberg, & Stevens, 1984).

In short, the professionals' definition of health and illness—in essence their power to name (Schur, 1984)—is a crucial factor in determining both perceptions of mental and physical capability and definitions of acceptable social roles for clients.

In this article I address the complex ethical and cultural issues that arise when counseling women, Blacks, ethnic minorities, poor people, lesbians, and gays. Common dilemmas arising from the social context of the counselor-client relationship, the need to respect client autonomy, and the imperative need for ethical and high-quality health care are outlined and discussed, and management strategies are suggested.

Client Autonomy and Welfare

Clients are products of their own cultural milieu. Their sex, race, ethnicity, social class, and sexual orientation determine when and how they seek help, their compliance with the recommended regimen, and, to a significant degree, the therapeutic outcome (Eisenberg, 1976). Consequently, when counseling ethnic and racial minorities, certain belief systems of the client must be considered if quality care is to be given (Eisenberg, 1976). This entails understanding and honoring folk belief systems such as (a) the humoral hot-cold theory of physical and mental disease (in which a wet, warm body is seen as healthy. Food, herbs, and medication, which are also classified as wet or dry and hot or cold, are therapeutically applied to restore the body to its supposed natural balance. This is still seen as relevant by many Puerto Ricans and Mexican Americans) (Harwood, 1971), (b) *Curanderismo* (the frequenting of folk healers self-taught in native and traditional healing arts) and belief in folk diseases among Mexican Americans in the Southwest (Martinez & Martin, 1966; Mull & Mull, 1981), and (c) religious healing rituals and practices (Hufford, 1977).

If counselors fail to integrate an appreciation for a client's own belief system, the ethical principle of beneficence is violated. *Beneficence*, defined as "doing good" by preventing harm to the patient and, furthermore, acting in such a way as to benefit the patient, is a principle that governs the counselor-client relationship. In this instance, the patient's welfare is intrinsically tied to his or her own belief system; in short, beneficent treatment ensures that the patient is not harmed through a disregard for his or her belief system and does, in fact, benefit from the counselor-client relationship. For example, among Mexican patients using an urban California clinic in 1980, 23% believed that expressing admiration for babies without touching them could make them ill. Of the residents and physicians who treated this clinic population, however, 60% reported not having encountered this belief. Similarly, 85% of these clinic patients attached great relevance to *susto* (i.e., fright sickness, the belief that causes fright illness). Of particular importance to counselors, this belief was not encountered by 60% of the residents (Mull & Mull, 1981). In this example two equally serious weaknesses in counseling overlap—ineffective treatment and, potentially, unethical treatment (violating the principle of beneficence and the patient's welfare).

Like ethnic factors, race contributes to the goals and values of a client and to the counselor's ability to provide effective care (see Casas article in the *Journal of Counseling and Development, 64*, 1986). Counselors must abandon preconceived notions of Black family structure, which may be seen as sociopathological, taking the two-parent patriarchal model as the desired norm. Furthermore, awareness of the pivotal role played in female-headed Black households by community resources, such as church, extended family, and clubs and schools, allows the counselor to address the patient's welfare through a realistic, therapeutic approach (Wilkinson, Connor, & Daniels, 1979).

Other common issues for counselors of Black clients include stressful and conflicting demands on Black women to emulate White standards of behavior and beauty, which have destructive effects on their psyches (Black Women's Community Development Foundation, 1975; Hull, Scott, & Smith, 1982; Morrison, 1970), and pressure for the sterilization of adolescent Black mothers. This pressure often conflicts with the clients' own morals, denies them an important source of self-worth (Black Women's Community Development Foundation, 1975; Cayleff, 1984), and fails to consider the extended kin network that figures so prominently in child rearing and mothering among Black women (Hale, 1980; McAdoo, 1980).

Furthermore, evidence suggests that Black patients may be treated differently than White patients with regard to medication, diagnosis, and politeness of treatment (Carter, 1983; Coles, 1969; Levy, 1985; Wood & Sherrets, 1982). This evidence raises ethical questions regarding respect for persons and ethical principles that assert that counselors treat people with respect when they view them as autonomous agents who are entitled to decide for themselves, to the extent that they are capable, what is in their best interest. Furthermore, treating Black clients differently impedes the ethical principle of distributive justice—the most defensible definition of which indicates that clients are entitled to similar treatment for similar cases, regardless of extraneous social, racial, and economic factors. Finally, research reveals that Blacks are likely to be counseled differently when making career decisions because of counselors' beliefs that they should pursue specific avenues of employment. For example, Black medical school graduates report being urged to choose primary care family medicine over a less service-oriented specialty on the presumption that they do or should want to "serve their own" (Suntharalingam, 1983).

This approach to counseling, in which the counselor slants information, is paternalistic. Paternalistic behavior reflects the counselor's belief that he or she is acting in the client's best interest; to this end the counselor may withhold or distort information. This behavior, in turn, compromises (a) the autonomy of clients, their ability to act in their own best interests in keeping with their cultural self-definition, and (b) rational decision making based on informed consent and awareness of viable options and their likely outcomes.

Like ethnic and racial factors, cultural dictates surrounding sex also affect the counselor-client relationship. Stereotypical sex roles prohibit strong disagreement between authority figures and clients. These roles are often reflected in the power-laden relationships between practitioner and client in the counseling setting (Raymond, 1982). Genuine communication with and autonomous decision making by women are thus often undermined by sex-specific factors. To discern the true autonomy of women, it may be necessary to establish women's own beliefs, as opposed to their socialized, sex-specific propensity to accommodate and attempt to please others (Gilligan, 1982; Kristeva, 1982). This necessitates a counselor-client relationship that is not paternalistic, stresses the client's welfare, and validates a desire for autonomy. In short, counseling women with an eye toward making them compliant to limited pursuits specific to their sex upholds neither their autonomy nor their welfare.

The necessity of developing and maintaining ethical and professional relationships based on the principles of beneficence, autonomy, justice, and welfare has been delineated. More specifically, strategies for coping with the dilemma in which a counselor finds himself or herself unable to respond with a reasonable degree of knowledge to the client's own cultural background include (a) helping the client choose an appropriate counselor; (b) if this is not possible, encouraging peer counseling situations; and, finally, (c) self-directed reading to increase understanding, coupled with consultation with indigenous community liaisons (e.g., women's centers, gay advocacy groups, Hispanic community groups).

Conclusion

Because of the many roles they are asked to serve, counselors face many ethical and cultural dilemmas. Counselors may misunderstand clients who are of a different sex, race, social class, or

sexual orientation than themselves. These cultural misunderstandings, in turn, may precipitate difficulties in communication, obscure expectations, affect the quality of care dispensed, and dramatically alter a patient's willingness or ability to maintain a therapeutic program (Roth, 1976). In short, the sex, race, class, and sexual orientation of the client must be considered, understood, and honored to prevent doing harm, serve the client's welfare, respect autonomous principles, and, ultimately, to provide effective counseling. Failure to integrate these factors into professional relationships infringes on the client's cultural autonomy, impedes the likelihood of an effective therapeutic relationship, and constitutes unethical behavior, because respecting the integrity and promoting the welfare of the client "through awareness of the negative impact of both racial and sexual stereotyping and discrimination" is the basis of an ethical counselor-client relationship (AACD, 1981, Section A.8).

The influence of cultural factors on counseling is complex. If counselors recognize that cultural beliefs affect responses, goals, and decision making within the counselor-client relationship, they will understand the force and influence of these cultural factors. This knowledge will, it is hoped, encourage counselors to develop research and training techniques as well as ethical guidelines for counseling racial and ethnic minorities (see Casas article in the *Journal of Counseling and Development, 64*, 1986) and ethical standards for cross-cultural counseling practice, counselor preparation, and research (see Ibrahim article in the *Journal of Counseling and Development, 64*, 1986). These guidelines, ideally, would caution counselors against using sex, race, ethnicity, class, or sexual orientation as a basis for imposition of culturally dominant beliefs, paternalism, condescension, misunderstanding, and even mislabeling of such clients as sick. By considering the impact of a client's cultural background on the contemporary counselor-client relationship, counselors can let the client's self-definition and belief system guide the course of the counseling relationship.

Dilemma Response

The counselor, with full knowledge of the extreme importance placed on mothering and reproduction in the social status, self-perception, and derivation of personal meaning for Mexican-American women like Maria Gonzalez (Mirande & Enriquez, 1979), acts and counsels as follows:

1. Tries to find a competent counselor who is also a fluent speaker of the client's language (an interpreter should be used only as a last resort).
2. Does not try to convince Maria that she must undergo the hysterectomy (this would compromise Maria's autonomous decision making and informed consent; it would be paternalistic and, possibly, would compromise her future familial welfare).
3. Emphasizes the aspects of mothering through which Maria will still be able to find pride, fulfillment, and self-definition.
4. Elicits the husband's participation in this situation so that (a) Maria does not feel as if she is being buffeted about between well-meaning health care workers and an uninformed, uninvolved, and anxious husband, and (b) Maria's husband comes to see it as their problem and not hers alone.
5. Uses a peer-support network (e.g., Hispanic women who have faced this situation).
6. Enlists the counseling intervention of Maria's minister, whose opinion she respects greatly and who might mitigate the husband's reaction.

Successful resolution of this case involves not only the prolonging of biological life but the maintenance of the client's welfare and autonomy as well. Furthermore, her understanding of the hysterectomy itself should be explored because informed consent measures physician disclosure and not patient understanding. The counselor should use enough support persons and facilities so that Maria returns to her cultural context with the prospect of self-esteem and familial relations left intact. The ultimate decision about whether to consent to the surgery is hers alone. In cases in which this type of psychosocial counseling is not provided, the woman most often, but not always, agrees to the surgery. This counseling, however, would acknowledge Maria's concerns and seek to use existing familial and community resources to minimize the realization of her fears.

Counseling Research: Ethics and Issues

Sharon E. Robinson and *Douglas R. Gross*

This article focuses on the areas of ethics and issues that relate to counseling research. The authors identify three global areas for research study: (a) clinical studies, (b) counselor training investigation, and (c) evaluation. Issues such as competency, informed consent, confidentiality and privacy, cooptation and manipulation, no treatment controls, validity and generalizability of results, and authorship are discussed.

> *Dilemma.* A researcher, wanting to measure the effect of shame and guilt on participants' willingness to self-disclose, used a tachistoscope to subliminally present messages such as, "You smell awful" and "We hate you." Such research, which focuses on the induction of negative affect, confronts the researcher with an ethical dilemma. Is it possible to protect the dignity and worth of the participant when using aversive stimuli? How can researchers satisfy their need to know and at the same time ensure the welfare of participants?

The desire to know is one of the special, unique characteristics of human beings. Ever since people first learned to talk, the word *why* has been prevalent in our thoughts and conversations. For many, this curiosity has intensified with age and education, and as adults they like to refer to themselves as researchers or scientists. Under the sanctity of such dignified titles, they pursue answers by designing research studies to discover "Why?" "What would happen if . . . ?" or "What does it look like . . . ?"

This picture of the researcher is incomplete, especially if the researcher is also a professional in the field of counseling. Presumably, as Bersoff (1978) pointed out, "Most research counselors engage in can be appropriately characterized as having therapeutic

intent. Counselors are interested in data-gathering to benefit the participant as well as future services" (p. 365). Counselor researchers make judgments about the individual therapeutic value of their research, but they must also weigh the cost-benefit ratio of the value of the research to society. There are times when a certain research project has potential for enhancing society at large but has no direct benefit for the participants. Finding a balance is not always simple. Fox (1973) suggested that

> some kind of dynamic equilibrium between the promises and perils of research, between individual and societal considerations, should ideally be struck—an equilibrium that does not immoderately embolden investigators and their subjects, unduly fetter them, or relegate them to an irresolute state of limbo. (p. 59)

Counselors doing research should be trained to design studies that attempt to answer research questions in an ethical and professional manner. Counselors also need training in various research methodologies to enable them to consider alternate approaches. Participants in research must be able to assume that the researcher is competent to conceptualize, to design, and to conduct the project within established professional standards. Researchers need to be aware that such participant reliance and trust may establish a fiduciary responsibility on the part of the investigator (Schwitzgebel & Schwitzgebel, 1980). If investigators violate their obligations to participants, they are liable for malpractice (Bersoff, 1978).

Having the necessary research knowledge and skills to conduct research often means that counselors have had formal classwork in research designs or methods and have had supervised experience in conducting research. The quality and quantity of this education itself may well become an ethical and professional issue. Furthermore, even if counselors do not want to conduct studies personally, they must be able to understand and to implement research findings. "In order to make choices not only about what to do to be an effective counselor, but also who or what to believe, one must be able to understand and to analyze methods, arguments, and conclusions" (Remer, 1981, p. 568). According to Remer, if one does less than this, one "cannot be a professional counselor" (p. 567).

Assuming that the counselor is competent to perform research activities, whether in clinical studies, counselor training investigations, or evaluation research, the following four ethical issues are

relevant: (a) informed consent, (b) coercion and deception, (c) confidentiality and privacy, and (d) reporting of results.

Informed Consent

Most counselors are employed in settings in which they provide direct service to clients or client systems. In such settings, both the client and the client system are potential research participants. If clients come to counseling because they are in emotional turmoil and are not making good decisions about their lives, can they objectively decide that being a research participant is good for them?

In the context of evaluation research, which often takes place in business and industry, the counselor is acting in a social system composed of people who relate to each other in a hierarchial manner and who have a collective identity as an organization. One of the ethical responsibilities of the counselor is talking to clients about their rights, including the right not to be studied. In such an organizational setting, however, this is not possible because, according to Mirvis and Seashore (1979), these people cannot be approached as individuals. Employees are often required to participate in the evaluation project only because they are employees of the organization. The lower they rank in the hierarchy, the less likely they will be given a chance to agree to involvement.

The American Association for Counseling and Development (AACD, formerly the American Personnel and Guidance Association [APGA]) *Ethical Standards* (1981) state that AACD members should enhance the dignity, worth, potential, and uniqueness of each individual. Can this be done if the client is also a "subject" for study? The right to choose not to be involved is guaranteed by the U.S. Constitution, which protects people's autonomy over what happens to them. Without informed consent, autonomous decision making is compromised. Several court decisions have reinforced the protection of the right to give informed consent (e.g., *Merriken v. Cressman*, 1973; *Natanson v. Kline*, 1960). According to Bersoff, the following six elements of informed consent need to be adhered to:

1. Fair explanation of the procedures to be followed and their purposes, including identification of any procedures that are experimental

2. Description of any attendant discomforts and risks that can reasonably be expected
3. Description of any benefits that can reasonably be expected
4. Disclosure of any appropriate alternative procedures that may be advantageous to the participant
5. An offer to answer any inquiries concerning the procedure
6. An instruction that the person is free to withdraw consent and to discontinue participating in the project or activity without prejudice to the subject. (Bersoff, 1978, p. 380)

Coercion and Deception

Coercion and deception closely parallel the issues of informed consent. As Corey, Corey, and Callanan (1984) indicated, clients are often "unclear about what is expected of them" (p. 193). Therefore, they may be particularly vulnerable to allowing themselves to be manipulated into being research participants. Diener and Crandall (1978) stated that 19% to 44% of recent psychological research involves "direct lying to subjects" (p. 74). To arrive at a valid answer to a research question, often the researcher cannot totally disclose all aspects of the research to participants. In such cases the researcher needs to investigate all other possible methods for arriving at an answer to the question before employing deception. Bersoff (1978) advocated telling the participants that they may be deceived and then giving them an opportunity to not participate. In many cases the best choice may be not to do the research.

Counselor training research often uses another type of "captured participant"—students. One finds in the issues of *Counselor Education and Supervision* or the *Journal of Counseling Psychology* that the majority of research participants are students. Students in classes such as Introduction to Psychology or Introduction to Counseling frequently are chosen for study as "samples of convenience." Too often the research is conducted as part of training, so no consent is obtained. Counseling literature is replete with such phrases as "this research was part of required class training" or "students were given class credit for participation." These statements stretch the limits of ethical behavior and contain elements of coercion. Because the researcher is often the class instructor, students may fear that refusing to participate will negatively affect their class grades. The researcher-instructor must try to avoid dual

roles and student manipulation while protecting student rights and freedoms, maintaining an effective research design, and adhering to principles of effective training.

In evaluation research, cooptation is possible because top management has tremendous power over lower-level employees (Robinson & Gross, 1985). Organizations are, by nature, systems of coercion, compliance, and accountability, and because of these characteristics employees are at risk if they refuse to participate (Gross & Robinson, 1985). Even though the information gathered from the research may help them and the organization to be more efficient and effective, the process is often "shoved down [their] throat" (Mirvis & Seashore, 1979, p. 767). The basic challenge for the counselor researcher is to protect the dignity and welfare of each participant while still achieving the objectives of the research. To meet this challenge, counselor researchers need to stipulate, during the initial contracting stages of the research, their need to protect the dignity and welfare of each participant. In so doing, they should make every effort to keep all participants informed about the nature and process of the research, explain participants' rights related to informed consent, keep deception to a minimum, and provide for debriefing at the conclusion of the research.

Coercion and manipulation also exist in the case of no-treatment controls. Some research is designed to help some participants and to leave others untreated. For instance, one group of college students in a college counseling center is given assertiveness training while another group receives no treatment. Because members of the latter group are not treated, their problems, presumably tied to a lack of assertive behaviors, persist. Is this practice ethical? Even if they had known they were on a waiting list, was their participation coerced and were they treated ethically?

Confidentiality and Privacy

All codes of ethics state that the counselor should hold confidential the disclosures of clients. Is the counselor breaching ethical standards if he or she uses client information in research even if the goal is to demonstrate the effectiveness of a treatment procedure? Not only are verbal disclosures confidential; so are tests, records, tape recordings, and other data. If counselors are to use any or all of these for research purposes, then the informed consent of clients must be obtained. Simply "changing the names to protect the innocent" is not sufficient protection of client privacy.

The concepts of confidentiality and privacy are also addressed by the question, "To whom do the data belong when research is being conducted for pay?" Many managers believe that because they hired the counselor, they should have access to all information. The counselor may not be able to guarantee confidentiality. An ethical dilemma is created by the tension between two powerful forces: (a) the employee, whose rights need to be protected and respected, and (b) the organization.

Security of test results and assessment instruments falls into the same problem area. Thus far, most of the court cases have focused on the issue of testing of employees (e.g., *Albermarle Paper Company v. Moody*, 1975; *Detroit Edison Company v. NLRB*, 1979; *Griggs v. Duke Power Company*, 1971). Several companies have taken positive steps to protect their employees' rights and freedoms by either limiting access to employee files or discontinuing the collection of large pools of information. Approximately one-half of the Fortune 500 companies have established strong rules of data confidentiality (Westin, 1978).

Solutions to these dilemmas are not simple. At the beginning of any paid research relationship, however, steps should be taken to establish a contract that provides answers to the following questions: (a) What types of data should be gathered and from whom? (b) What provisions will be made for nonparticipation? (c) Who owns the data? (d) What are the parameters of confidentiality? and (e) How will the data be reported?

Reporting of Results

Additional ethical dilemmas are connected with the reporting of findings. Limited generalizations must be made from small, nonrandom, or homogeneous samples. Too often psychometric properties of tests and instruments are never mentioned in the final report. Also, the researcher must give appropriate credit to everyone involved in the research. Establishing an alpha level that will allow for "practical significance" is just as important as "statistical significance" at the .05 or .01 probability level. Editors and editorial board members often reject research that has not reached these sacred probability levels. Perhaps if researchers made more eloquent arguments for the impact of their findings, regardless of statistical significance, editors would publish more research that has applied relevance.

According to Adair, Dushenko, and Lindsay (1985), another ethical dilemma in the reporting of results centers on the omission of information pertaining to such ethical procedures as informed consent, freedom to withdraw, use of deception, and procedures dealing with participant debriefing. These ethical practices, although stipulated in codes of ethics, are often not reported in published results. Blame for such oversights must be shared both by authors, who are not encouraged to report such information, and by editors, who, through their publication manuals, do not stress this type of information.

Conclusion

Counseling research is not clean and simple. If the field of counseling is to evolve professionally, counselors who also refer to themselves as scientists or researchers need to continue to avoid ethical pitfalls and to answer questions about human behavior that will improve their service to others. Regardless of the research domain, ethical issues such as informed consent, confidentiality and privacy, cooptation, manipulation, deception, participants' right to treatment, and honesty in reporting results need to be considered. The following safeguards are necessary for ethical research:

1. People conducting research for pay, whether in the private or public sector, should develop a contract at the beginning of the process that addresses the ethical issues discussed above.
2. People conducting research must be educated in the codes of ethical conduct related to both counseling and research as set forth by the professional associations.
3. People conducting research must evaluate their levels of knowledge and skill in the area to be researched and decide whether they have the expertise to design, conduct, and interpret results that are protective of participants.
4. People conducting research should establish "human subject committees" that would review, evaluate, and either approve or deny the conducting of the research based on its impact on the participants involved.

The ethical dilemma presented at the beginning of this article can be addressed by (a) presenting subliminal praise messages to each participant, (b) thoroughly debriefing each participant,

(c) arranging for participants to talk to a counselor if they so wish, and (d) seeking the approval of a "human subjects experimentation committee" (Mitchell, 1984).

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Boundaries of Sex and Intimacy Between Client and Counselor

Eli Coleman and *Susan Schaefer*

Numerous factors have contributed to increasing debate regarding sexual and intimacy boundaries between clients and therapists. Although having sexual contact with a client within a therapeutic relationship has been defined as unethical behavior, ways to deal with these potential situations have been less well defined. In addition, there are disputed areas of ethical behavior. The authors review these various ethical dilemmas and make some recommendations.

> *Dilemma.* A woman comes to see a male counselor and complains of anxiety and depression associated with her recent divorce. She is also deeply concerned about her attractiveness and ability to attract another partner. The thought of single life frightens her. After five or six sessions, she confesses to the counselor that she is deeply attracted to him. Although she finds him sexually attractive, she is equally or more attracted to his sensitivity, care, and support of her. Emotional intimacy is something her previous relationships have lacked. And, at times, those relationships have been abusive.
>
> The counselor does not know how to respond. He too is attracted and has already fantasized about a relationship with her. But because she is a client, he does not dare reveal his feelings. He knows that allowing a relationship to develop would be wrong. That, however, does not solve the problem.

Most people would agree with the counselor that sexual contact within a counseling relationship is unethical (e.g., Dahlberg, 1970; Edelwich & Brodsky, 1982). But few have offered suggestions on handling these types of situations. The dilemma is complex and

dealing with it is difficult. In this case, the counselor determines that he has six options: (a) reveal his own feelings and suggest terminating the counseling relationship so they can have a relationship; (b) transfer her to another colleague, giving her the true reason for the referral; (c) deny his feelings and discuss the client's attractions as a natural part of transference that occurs in therapy; (d) discuss his ethical dilemma with his supervisor or supervision groups; (e) acknowledge the client's feelings and restate the professional boundaries of the counseling relationship; or (f) explore these feelings with the client while continuing the counseling relationship.

The complexity of this ethical dilemma increases when one considers boundaries of other types of intimacy (e.g., affection, support) that are shared with a client. What types of intimacy are appropriate? What types are not? These dilemmas are faced by counselors at one time or another. Indeed, the entire range of sexual and intimacy boundaries between client and counselor is the subject of growing debate. Numerous factors have heightened the debate, including increased complaints against counselors, new ethical guidelines adopted by professional organizations and licensing boards, increased lawsuits against counselors, the creation of state task forces to consider legislation regarding sexual contact between clients and counselors, and the adoption of specific legislation governing counselor behavior.

For instance, in 1984 the Minnesota state legislature enacted a task force on sexual exploitation by psychotherapists after numerous complaints by victims who were clients that there was little effective recourse against abuse from counselors. The Minnesota state legislature passed several bills that now make it a felony if a counselor has sexual contact or intercourse with a client during the therapy session. Beyond the session itself, the counselor may still be found guilty of criminal sexual conduct under certain circumstances. In most cases, client consent cannot be used as a defense.

As a result of a similar task force, in May 1984 Wisconsin enacted a new law, which states, in part, that "any physician, psychotherapist, or any person who is, or holds him/herself out as a therapist is guilty of a Class A misdemeanor when he/she imposes sexual contact on a patient or a client during any treatment, consultation, interview or exam" (Criminal Code, State of Wisconsin, 1984). Laws similar to these will likely be enacted in other states but face constitutional challenge in the courts.

Professional licensing boards in recent years have also adopted rulings on sexual conduct. In addition to recognizing sexual activity

between client and therapist as unethical and punishable, some licensing boards have established mandatory reporting guidelines. For instance, in 1982 the Minnesota Board of Psychology passed a ruling making it mandatory for all psychologists to report any knowledge of sexual exploitation by other psychologists unless that knowledge is gained during therapy with the abuser. Since then, the Minnesota Board reports that complaints have tripled.

Insurance companies, too, are concerned about the problem of sexual misconduct in therapy. According to Bill Burck, claims representative at Fred S. James and Company of Texas, Inc., one of the major insurers of members of the American Association for Counseling and Development (AACD), sexual misconduct claims have risen dramatically in recent years and are now second only to fee-dispute claims (B. Burck, personal communication, September 1985). We conjecture that this increase is responsible for the recent decision by the James Insurance affiliate, Interstate Insurance Group, to terminate malpractice insurance for AACD psychologist members. Whether AACD, in conjunction with James Insurance, will be able to find another insurance underwriter is in doubt at the time of this writing.

Claims can only suggest the extent of the problem. Feldman and Ward (1979), professors of law, suggested that even more malpractice cases are not brought against counselors because of the many legal and psychological obstacles that confront clients. These obstacles, however, are currently being reviewed.

As for the profession policing itself, the standards established by AACD are clear: Sexual activity between client and counselor is an ethical violation. Section A.8 of AACD's (formerly American Personnel and Guidance Association) *Ethical Standards* (1981) states: "In the counseling relationship the counselor is aware of the intimacy of the relationship and maintains respect for the client and avoids engaging in activities that seek to meet the counselor's personal needs at the expense of that client." More specifically, Section B.11 warns that "Dual relationships with clients that might impair the member's objectivity and professional judgment (e.g., as with close friends or relatives, sexual intimacies with any client) must be avoided and/or the counseling relationship terminated through referral to another competent professional."

But in reading these statements, one cannot be sure whether continuing or beginning an intimate or sexual relationship with a client after he or she has terminated the counseling relationship is an ethical violation. Without clear guidelines, counselors must make their own ethical decisions. It should be noted, however, that much

of the testimony from clients at a recent task force hearing in Minnesota involved complaints against psychotherapists who became involved with clients after therapy had terminated (Task Force on Sexual Exploitation by Counselors and Therapists, 1985). Sentiment seems to be building that this is an ethical violation too.

The Extent of the Problem

The most commonly cited study of abuse in psychotherapist and client relationships was conducted by Kardener, Fuller, and Mensh (1973). They questioned various physicians about sexual involvement with their patients and found that 10% of psychiatrists admitted erotic contact with their patients (5% indicated that this contact included sexual intercourse).

A sample of 1,000 psychologists (500 men, 500 women) was asked similar questions by Holroyd and Brodsky (1977). They found that 10.9% of male psychologists acknowledged having erotic contact with their clients and 5.5% admitted having sexual intercourse. Significantly different statistics were found for female psychologists. Only 1.9% of the female sample admitted erotic contact with clients, and 0.6% admitted having sexual intercourse.

Although these studies show that only a small group of professionals have been involved with their clients, the occurrence of this erotic contact at all is disturbing. What may be most disturbing are findings that most professionals who admit having had erotic contact with their patients report more than one incident: 80% of Holroyd and Brodsky's (1977) sample and 75% in Butler's (1975) study.

Although the stereotypical notion of male counselors abusing female clients has been supported up until now, recent research has indicated that more abuse may involve the female counselor with a female client, a female counselor with a male client, or a male counselor with a male client than was previously indicated. In a study by Schoener and Milgrom (in press) of 350 clients reporting sexual abuse by a counselor, 10% of the cases involved a female client and a female therapist. Very few cases of abuse involving a male counselor and a male client (3%) or a female counselor and a male client (2%) were reported.

In another recent study by Bouhoutsos, Holroyd, Lerman, Forer, and Greenberg (1983), more male counselor and male client cases were found than female counselor and female client cases. Schoener and Milgrom (in press) and Bouhoutsos et al. (1983) cau-

tioned that their results may simply reflect regional sampling differences. Schoener and Milgrom also warned that many homosexual types of abuses do not always involve a homosexual counselor. Many male and female counselors have become involved with same-sex clients as a result of experimentation with same-sex relationships and have not previously held a homosexual identity. Abuse, therefore, can occur with any combination of sex and sexual orientation of counselor and client.

The Abusing Counselor

Other than incidence statistics, very little is known about the abusing counselor. Dahlberg (1970) and Butler and Zelen (1977) have found these counselors to be lonely, vulnerable, and needy themselves. After reviewing nearly 400 complaints of sexual misconduct by counselors with their clients, Schoener (1984) labeled five levels of disturbance on the part of the offending counselor.

The first level is episodic. The offender has made an isolated decision to become involved with a client that reflects bad judgment, loss of control, or strong environmental factors. These offenders are usually remorseful about their actions and have a good prognosis for rehabilitation. Unfortunately, they represent a very small number of the cases Schoener reviewed.

The second level of disturbance is neurotic. These counselors are often socially isolated, lonely, and seek intimacy with their clients to satisfy their own intimacy needs. The types of affairs they have with their clients may not always be overtly sexual.

Compulsive character disorders represent the third level and one of the most common types of offending counselors. These offenders are similar to the chronic sexual offender. Layers of rationalizations, combined with a lack of control over their behavior, make these counselors very difficult to rehabilitate. They are often caught and disciplined, but this is not enough to prevent further abuses.

On the fourth level are those with narcissistic character disorders. These counselors are grandiose, deluded, and self-centered. In a delusional way, they believe that whatever they do is good for other people even if they are confronted with irrefutable evidence to the contrary. They usually have no remorse over their activity and justify their behavior without qualms.

Finally, on the fifth level are those who are schizophrenic or psychotic. Only a few counselors fit this category.

The Abused Client

Studies that have explored characteristics of clients who have been sexually abused by their counselors have found that the female victims were 12 to 16 years younger than their counselors (Belote, 1977; Bouhoutsos et al., 1983; Butler, 1975; D'Addarrio, 1978; Stone, 1981). These clients have been described as lonely, unhappy, and suffering from low self-esteem. Most are externally focused rather than internally directed. Many have a previous history of incestuous relationships or abuse by professionals. With their history of violations of their personal, psychological, and physical boundaries, which may or may not have been sexual, they are particularly vulnerable to this form of abuse.

A Continuum of Sexual and Intimacy Abuse of Clients

Although direct sexual contact is clearly abusive and unethical, it is important to broaden the framework of abuse to incorporate the psychological dynamics that underlie and set the stage for the occurrence of more blatant abuse as well as covert sexual behaviors that may be equally damaging. Conceptually, then, sexual and intimacy abuse of clients by counselors may best be viewed along a continuum consisting of psychological, covert, and overt abuse (see Table 1).

Psychological Abuse

Within this framework, the psychological column refers to aspects of the counseling relationship in which the client is put in the position of emotionally caretaking the needs of the counselor. This situation typically arises when poorly defined boundaries are set by the counselor as well as by the counselor's own "neediness." This constitutes an intimacy violation. The following is a case illustration:

> After a few counseling sessions, Dave asked his counselor to go have a cup of coffee, and he agreed. Initially, Dave was flattered that his counselor liked him enough to want to spend time with him outside of counseling. He enjoyed his counselor's company and thought it would be nice to have him as a friend.

Table 1

CONTINUUM OF SEXUAL AND INTIMACY ABUSE BY COUNSELORS

Psychological	*Covert*	*Overt*
Therapist meeting own intimacies through client	Sexual hugs	Sexualizing remarks
Role reversal with client	Professional voyeurism	Passionate kissing
Self-disclosure with no therapeutic value	Sexual gazes	Fondling
Loosely defined parameters of the therapeutic relationship	Over-attention to client's dress and appearance	Oral or anal sex
	Therapist's seductiveness through dress or gestures	Sexual intercourse
		Sexual penetration with objects

Meeting in this setting, Dave's counselor told him much more about himself and that he was having marital problems. Again, Dave was flattered by this display of trust. It made him feel important. As time went on, Dave and his counselor began to see more of each other socially (e.g., having dinner together, playing racquetball, inviting each other to parties). At one point Dave's counselor called him, looking for support. The counselor had just learned that his wife had asked him for a divorce. At this point, Dave began to question the value of his counseling sessions.

In this case the therapist had reversed roles with the client and had engaged in a form of psychological intrusion. He failed to take responsibility for setting the boundaries of the relationship and met his own personal needs at the expense of the client.

Counselors who are experiencing grief or loss in their lives, such as Dave's counselor, are at greater risk for boundary violations and therefore should seek out additional outside support during these periods of vulnerability. In this way, such counselors are less likely to turn to their clients to meet these emotional needs. Counselors should be particularly watchful of their use of self-disclosure during these times. There is often a tendency to overindulge in

self-sharing beyond the point of any therapeutic merit to the client. Before self-disclosing, counselors should consider whether the information is intended to broaden or deepen the client's understanding of his or her own issues.

Along with the content of therapy, the counselor should be cognizant of the importance of the structure of therapy and how this structure communicates boundaries of the counseling relationship. When a counselor ignores fees, fails to hold a client accountable for missed appointments, allows sessions to run overtime, accepts social invitations from clients, or interprets policies differently for certain clients, ambiguities in the professional relationship are communicated. These ambiguities often undermine a counselor's power and lead to more blatant forms of intrusion.

It is also important to realize that many clients are victims of boundary invasion (a physical or psychological intrusion that is experienced as unwanted and painful, e.g., emotional, psychological, physical, or sexual abuse) in relationships outside of counseling. Because of these experiences, many clients become confused and may misunderstand different forms of intimacy shown during counseling. They also may not be able to set appropriate boundaries for themselves. To avoid confusing the client, the counselor needs to establish clear boundaries by adhering to the principle of separation between a therapeutic relationship and other types of intimate relationships (e.g., with a friend or lover).

Covert Abuse

Moving along the continuum to the covert category (see Table 1), the counselor's boundary confusion with the client becomes more pronounced as the counselor displays behaviors with intended sexual connotations to the client, thus intruding further on the client's intimacy and sexual boundaries. The following are several common forms of covert sexual abuse that may occur in the counseling relationship:

Sexual hugs. These are hugs that are intended to arouse or satisfy the counselor's sexual needs rather than give support to the client.

Professional voyeurism. The counselor probes into the client's sexual history or practices to satisfy the counselor's curiosity rather than to produce any potential therapeutic gain for the client.

Sexual gazes. The counselor gives the client the "once over" while entering the room or stares at the client's sexual body parts during the session.

Although these behaviors are ambiguous in nature and their intent is somewhat camouflaged, they still possess sexual overtones. These behaviors confuse the client and cause him or her to wonder about the intent and how to respond. Again, these behaviors are damaging, abusive, and unethical.

Overt Abuse

Further along the continuum are examples of overt sexual behaviors, which may range from sexualizing remarks (e.g., propositions, sexual name calling, lascivious references to the client's sexual self) through some type of sexual contact or intercourse.

This category has been the most clearly recognized form of counselor abuse. Bouhoutsos et al. (1983) found that 90% of sexually abused clients experienced harm ranging from mistrust of opposite-sex relationships to hospitalization and, in some cases, suicide. Depression, emotional disturbances, impaired social adjustment, and increased use of alcohol and drugs were commonly reported symptoms. Clients typically found that their primary relationship worsened. Although their emotional problems increased, these clients found it more difficult to seek out further therapy because of their previous abusive situation.

For some clients, however, the psychological and covert forms of abuse may be the most damaging. When the behaviors have been made overt, the ethical violation is clear and the client can feel justified in his or her feelings of abuse. Psychological or covert forms of abuse, however, may provide more feelings of confusion, guilt, and shame.

Disputed Areas

Once counseling has ended, can intimacy be established? There are no ethical guidelines that seem to address this issue directly. Van Hoose and Kottler (1978) argued:

> If the therapist does genuinely believe that he is in love with his client, he has an ethical responsibility to terminate the therapy and refer the client to a colleague who can more appropriately be of service. Now, if that therapist decides to continue his personal feelings for the client, he may do so with clear conscience. (pp. 55–56)

The following case illustrates this issue:

> Mae was a 21-year-old woman who sought counseling at the small college she attended. She decided to see a school counselor because she was recently divorced and was having problems adjusting to being single again. Her relationship history included an abusive relationship with her ex-husband and physical, verbal, and sexual abuse from her father.
>
> It was unclear to her whether she or her counselor initiated the lengthy discussion about their mutual physical attraction to one another. Soon thereafter, the counselor abruptly ended the counseling and provided her with a referral to another counselor.
>
> They began to date one another 6 months after the counseling terminated. The counselor abruptly terminated the personal relationship 5 months later. Mae felt rejected and further victimized by this experience.

In this case, the counselor was faced with a variety of ethical dilemmas. Faced with the dilemma of providing professional care and serving his own romantic interests, he decided to terminate the counseling and make a referral. He thought he acted properly, but the result was a negative experience for the client. As in this case, it is probably unlikely that a counseling relationship can ever successfully evolve into a healthy intimate relationship and questionable whether this risk should ever be taken. Such an intimacy is negatively affected by the power imbalance implicit in the counseling relationship, the process in which counseling becomes internalized, and the continuation, in many ways, of the counseling relationship for years after counseling has ended.

There are several other disputed areas in defining the sexual boundaries between client and counselor. One is the use of sex surrogates. Most therapists agree that it is unethical for the therapist to function as a sex surrogate. Many sex therapists, however, believe that the use of sex surrogates in sex therapy is an ethically permissible way of establishing a therapeutic environment to facilitate sex therapy (see Masters, Johnson, & Kolodny, 1977, for further discussion). Ethical guidelines concerning the use of sex surrogates have been established by the American Association of Sex Educators, Counselors, and Therapists (1981). These guidelines state: "... it should be understood that the partner surrogate is not a sex therapist ... and sex therapists working with partner

surrogates must exercise diligence and concern for protecting the dignity and welfare of both the surrogate and the client." These ethical guidelines are essentially the same as those of the International Professional Surrogates Association (n.d.).

Other disputed areas include the use of nudity in counseling, structured sexual fantasy exercises, and professionals' use of therapeutic massage as part of their practice. These areas need further exploration and ethical guidelines.

Recommendations

All counselors need to ask themselves how to responsibly set boundaries that deal with sexual and intimacy issues between themselves and their clients. Each counselor should ask the following questions:

1. In what ways do I behave differently toward my clients, in terms of time spent, intimacy, and touch? Can I back up these choices clinically?
2. How do I set boundaries for my sexual attraction to a client? For my client's sexual attraction to me?
3. Are there ways in which I am getting my intimacy needs met through my clients?
4. In what ways do I specifically state to my clients the parameters of the professional relationship?
5. How often have I raised ethical judgment calls, questions, and concerns to other professionals?

Conclusion

These questions may raise issues for all counselors. To resolve these ethical dilemmas, the counselor needs to discuss these issues with his or her colleagues in peer and other types of supervision. This is especially true when dealing with disputed areas in which licensing boards and professional organizations have provided little or conflicting ethical guidance. It is also important to keep up with changes occurring in state and national licensing boards, state legislation, and professional associations. Above all, in facing these ethical dilemmas, the counselor must take responsibility for setting appropriate sexual and intimacy boundaries for the client, com-

municating these boundaries, and keeping the relationship a professional rather than a personal one.

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